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Gilmour Psychological Services®

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Note highlighted text on pages 4 & 5.

March 27, 2017

To Whom It May Concern:

Re: Ms. Deirdre Moore, DOB: 28/09/1965

I have been seeing Ms. Moore since January 13, 2016 for consultations on an episodic basis as she goes through several life transitions. The following will clarify my professional opinion about Ms. Moore and some matters that seem to have developed over the past few years.

It must be noted that I have only seen Ms. Moore and read a binder of material that she shared with me. I have not seen her estranged husband, Jonathon Kiska, nor have I seen her children. Therefore, I have no comments to make about the divorce issues and any custody and access issues. I am only focused on my understanding about Ms. Moore, gleaned through my meetings with her and some of her writings. Furthermore, this report should not be interpreted as being an Independent Psychological Evaluation.

The following will begin with a brief description of my professional competence and then explain my understanding of Ms. Moore and what she has experienced. I will then discuss Ms. Moore's results on two Psychological Tests that I administered: the Minnesota Multiphasic Personality Inventory – 2RF (MMPI-2RF) and the Inventory of Altered Self-Capacities (IASC). These tests are described in Appendix A. My formulation will include her diagnosis, an explanation of what it means, and what her personal strengths and weaknesses are.

This report was prepared at Ms. Moore's request and in relation to her recent life experiences, and is most appropriately interpreted and used in this context. Also, my professional opinion expressed in the Formulation and Conclusions section is based on the information and data available to me at this time and could change if other information were to come to light.

Brief Statement of Professional Competence

I am a clinical psychologist, licensed since 1981. I am the founding psychologist of Gilmour Psychological Services® in Ottawa, established in 1983. I have the competency to assess, diagnose, treat and consult about most adult mental

health disorders, as described in the DSM-5 or the ICD-10. I have special interest and proficiency in the diagnosis and treatment of substance use disorders, recognized by my having earned the American Psychological Association's Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders. I have many years of training and experience in the diagnosis and treatment of adult children of dysfunctional families, adult survivors of childhood trauma and adult trauma survivors. I also assess and treat people with codependency, depression, anger disorders, anxiety, adjustment and life transition issues, self-esteem issues, stress, intimacy and major mental illnesses. I have years of experience applying my ethical and jurisprudence knowledge to the assessment of fitness to practice and standards of care. I also have many years of experience in providing Independent Psychological Evaluations in the context of civil suits for psychological trauma, certain retrospective criminal assessments and standards of care tribunals. I have testified as an Expert Witness in a number if civil suits and tribunals. Many of the cases for which I provided evaluation reports have settled out of court. I remain as committed and as enthusiastic as ever in providing the highest level of service in evidence-based counselling, psychotherapy, psychodiagnotics and Independent Psychological Evaluations.

Ms. Moore's Experiences over the Past Four Years

The following discussion of Ms. Moore's recent history is expressed in my words and not Ms. Moore's except where I use quotation marks. Also, the following is not meant to be a verbatim account of the incidents and events of her recent life, but rather a precis of the points that I believe to be salient. The following is based on Ms. Moore's self-reports and the documents that I have read.

In her first interviews with me, Ms. Moore reported that she was going through a divorce precipitated in part because she had learned that her husband had lied to the physicians and psychiatrists about her personal history and her recent past behavior, exaggerating, in her view, her behavior and the length of time that she had been acting strangely. She said the psychiatrists at the emergency department of the hospital asked her husband for information about her (as a collateral source of information) in spite of her having told them that he was verbally and psychologically abusive to her. She said that he listed many of the symptoms of Bipolar Disorder, which led the psychiatrists to diagnose her as having that disorder, and that diagnosis followed her through her various efforts to get help through the medical system and the police.

She said that she only realized what was happening when she obtained copies of her medical files and saw all the misrepresentations that her husband had told the physicians. She also said that her husband alienated her family members from her because of his misrepresentations of what she was going through.

Ms. Moore said that she stumbled on an article about "gaslighting" and realized that her husband was manipulating her so that she would become self-doubtful

and malleable. Gaslighting colloquially refers to a form of emotional abuse that causes the victim to question her experience of reality, resulting in increased control by the gaslighter. The term is a reference to a 1944 movie called Gaslight, in which a husband with a secret gradually tries to drive his wife insane. In current parlance, the gaslighter minimizes his victim's concerns and feelings insisting that the victim is too sensitive; "forgets" his promises and suggests that she was making things up; tells the victim that he had told her something or done something that she was sure he had not done; questions the victim's memory; changes the subject to divert her train of thought, and challenges and negated her emotional reactions. Lying about the wife's symptoms to psychiatrists would fall in the domain of gaslighting.

As a result of her feelings that her husband was psychologically abusing her, Ms. Moore left her family and stayed with a friend, seeing her children at the family home before and after school. She said that she realized when her stress got very high, she would have a brief psychotic episode. When she was in hospital, she would be treated with medication for Bipolar Disorder because she had been misdiagnosed based on what her husband had told the physicians. She reported that the side effects of the mediations made her ill and she did not feel that the physicians heard her because they were misled by what her husband had told them.

I did not see Ms. Moore between the end of March and December 8, 2016. She told me that due to finances, she attempted to reconcile with her husband for a period between April, 2016 and the fall of 2016. She said that in the fall, she recognized her husband's machinations, and began to feel unsafe with him. She left for an apartment and began a cycle of access with her children.

Ms. Moore said that she had also learned the early warning signs of being stressed to the point of being at risk of a brief psychotic episode. As a result, she takes her medication as prescribed and uses a tablet of clonazepam whenever she feels very anxious. She also tries to control aversive situations so that her stress level remains manageable. She successfully followed legal procedures and had a tenant removed from her house and now is in the process of moving into it.

Psychological Test Results

To clarify Ms. Moore's diagnosis, on February 2, 2017, I administered the MMPI-2RF and the IASC. The MMPI-2RF has validity scales which determine the test-taking attitude of the examinee. Ms. Moore's validity scales indicated that she was open and forthright in answering the questions, which concurs with my clinical impressions. As a result, I am confident that the results discussed below are an accurate reflection of Ms. Moore's current psychological functioning.

On the MMPI-2, most of the scales were in the normal range. There were small elevations on the Ideas of Persecution scale and the Antisocial scale. These were raised because Ms. Moore is very mistrustful of certain people including

her husband and she has felt persecuted and misunderstood by many (but not all) in the health system. The elevated antisocial scale was raised because she truthfully answered that she has had dealings with the police.

All of the Somatic, Cognitive and Internalizing scales were in the normal range. Also all of the Externalizing, interpersonal and Interest scales were in the normal range, with the exception of the Juvenile Conduct Problems. This scale was raised because of misbehavior as an adolescent and an angry suicide gesture as a teen (not an attempt). All of the Psy 5 (personality) scales were in the normal range, with the exception that she displayed a mild tendency to be introverted rather than extroverted.

Ms. Moore's results on the IASC were all in the normal range except for an elevation of the Interpersonal Conflict scale, raised, in my opinion, because of the conflict with her husband. There was also an elevation on the Susceptibility to Influence scale, which suggests that she can be easily led and was easily influenced by those close to her, such as her husband. Finally, the Affect Skills Deficit scale was elevated, indicating that Ms. Moore feels that she requires help in learning skills to soothe strong emotion.

What is striking about her results is that the vast majority of the scales are in the normal range. This suggests that her basic personality, character structure and usual mental status are normal and sound.

Formulation and Conclusion

In my opinion, Ms. Moore has many psychological strengths. She is a very intelligent, verbally fluent and articulate woman with a prosocial value system and good family values. She has a good work ethic and has very good social skills. She has persevered in the face of adversity and has good insight into her mental illness, which is a relatively small part of her psychological makeup.

It is true, however, that Ms. Moore has a mental illness. She reported that the brief psychotic episodes first appeared in 2013, precipitated by the high conflict with her husband. In my opinion, her diagnosis is Brief Psychotic Disorder, with marked stressors during which she has delusions and disorganized speech and cognitions. Brief Psychotic Disorder is diagnosed when the duration of an episode is at least one day but less than a month. Also, her symptoms occur in response to events that would be markedly stressful to almost everyone in similar circumstances.

Ms. Moore's first two hospitalizations were longer than one month, but, in my opinion, this was due to the repeated and ongoing stress she experienced when the professional staff would not listen to her or consider that her husband was not an accurate informant about her history or symptoms. Ms. Moore was repeatedly told that she was so sick that she was amnesic for her over-spending and other aberrant behavior. Having no one believe her or listen to her stressed

her so much that her psychosis could not remit until she was released and found a placed to live where she felt safe.

However, although I believe that the most accurate diagnosis is Brief Psychotic Disorder, the diagnosis that she was discharged with, that of Psychotic Disorder NOS (Not Otherwise Specified), is not in conflict with my overall discussion of Ms. Moore. Furthermore, due to the clinical acumen of Dr. Deanna Mercer, psychiatrist, Ms. Moore is very stable on Lamotrigine 200 mg, Clonazepam as needed and Immovane when she needs a sleep aid. Due to Ms. Moore's insight, she is able to add the "as needed" medications appropriately to prevent a reoccurrence. Also, she tries to avoid highly stressful situations, but can handle everyday stressors well.

I hope that this report is clear and useful. If you have any questions, please let me know.

Yours truly,

Dr. Iris Jackson, C. Psych.